

Hyponarrativity and Context-Specific Limitations of the DSM-5

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1. Introduction

This article develops a set of recommendations for the psychiatric and medical community in the treatment of mental disorders in response to the recently published fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, i.e., DSM-5. We focus primarily on the limitations of the DSM-5 in its individuation of complicated grief, which can be diagnosed as Major Depression under its new criteria, and Post-Traumatic Stress Disorder (PTSD). We argue that the hyponarrativity of the descriptions of these disorders in the DSM-5, defined as the abstraction of the illness categories from the particular life contingencies and personal identity of the patient (e.g., age, race, gender, socio-economic status), constrains the DSM-5's usefulness in the development of psychotherapeutic approaches in the treatment of mental disorders. While the DSM-5 is useful in some scientific and administrative contexts, the DSM's hyponarrativity is problematic, we argue, given that the DSMs are designed to be useful guides for not only scientific research, but also for the education of medical practitioners and for treatment development. Our goal therefore is to offer suggestions for mental health practitioners in using the DSM-5, so that they can avoid/eliminate the problems that may stem from the limitations of hyponarrativity. When such problems are eliminated we believe that effective psychotherapeutic strategies can be developed, which would be successful in repairing the very relationships that are strained in mental disorder: the patient's relationship to herself, her physical environment,

and her social environment.

2. Hyponarrativity in the DSM-5

The Diagnostic and Statistical Manual of Mental Disorders (DSM) offers the standard criteria for the classification of mental disorders. It is designed for pragmatic use across a variety of settings to accomplish a plethora of tasks: to facilitate clinical treatment, to develop educational programs about mental illness, to provide clear criteria of eligibility for various administrative and policy related purposes, including the determination of insurance coverage and disability aid, to further scientific research into mental disorder etiology, psychopharmacology, and forensics.ⁱ It is thus used to meet the needs and serve the interests of a variety of stakeholders, including patients and their families, researchers, clinicians, educators, pharmaceutical companies, and insurance companies. The manual is regularly revised and the criteria for mental disorders are adjusted to reflect the level of knowledge about mental disorders and their treatment as science progresses. So far, the manual has five editions, and there are ongoing conversations on a revision of the DSM-5.

The DSM-5 lists the criteria for mental disorders according to observable and scientifically measurable symptoms (experienced by the patient) and signs (observed by others). Polythetic criteria sets, as opposed to monothetic criteria sets, are used to determine the boundaries of a disorder category. Monothetic classifications are based on the characteristics that are both necessary and sufficient for the identification of members of a class; each member of a class must have at least one property shared with all members of the class. In polythetic classifications, each individual member of a class shares a large proportion of its properties with other members but all members do not necessarily share any one property.ⁱⁱ For instance, according to the criteria for depression in the DSM-5, at least five symptoms have to be present

during a two-week period and must represent a change from the patient's previous functioning: either "depressed mood" or "diminished interest in and pleasure from daily activities" must be among the five. Additional symptoms include: significant weight loss or gain; insomnia or hypersomnia; psychomotor agitation; fatigue or loss of energy; feelings of worthlessness or inappropriate guilt; and diminished ability to think or concentrate, indecisiveness, recurrent thoughts of death, and suicidal ideation (DSM-5 2013, 125).

The symptom-based classification of mental disorders (also called the descriptive approach) was adopted in the DSM-III (1980) and guided both the DSM-IV (1994) and the recently published DSM-5 (2013). The development of this approach was an expression of psychiatry's move towards an evidence based scientific framework, away from the etiological approaches of the DSM-I (1952) and the DSM-II (1968). These earlier approaches relied on empirically undefended theoretical assumptions about the workings of the mind, rather than outwardly observable correlates of disease. Mental disorders, also called "reactions," in these manuals, were represented in relation to the causal factors thought to underlie them.ⁱⁱⁱ These causal factors were described in the framework of psychoanalysis and taken either as a dysfunction in the brain or a general adaptational difficulty to environmental stressors due to unresolved sexual conflicts of childhood.

A symptom-based approach replaced this framework in the DSM-III, because clusters of symptoms and signs, by virtue of their observability and measurability, were thought to facilitate objective scientific research and reliable clinical diagnosis. A scientifically valid category of mental disorder requires external validators, such as symptoms, and signs, not simply theories.^{iv} Thus, symptom and sign clusters were resourceful constructs for scientists whose goal was to better investigate the neurological and genetic underpinnings of mental illness.^v From the clinical

perspective, these “consensus-based lists” of criteria afforded clinicians a sense of certainty in an area of medicine where no physiological tests are plausible.^{vi} Finally, symptoms and signs, by virtue of being empirically validated, allow diagnostic categories to be reliably and consistently used across clinical settings, thereby establishing a “shared discourse in the presence of competing and incompatible theoretical and etiological assumptions about mental disorders.”^{vii} As stated in the DSM-III, through a descriptivist approach, “clinicians can agree on the identification of mental disorders on the basis of their clinical manifestations without agreeing on how the disturbances come about.”^{viii}

One significant disadvantage of operationalizing a symptom-based approach is the level of abstraction in the individuation of mental disorders.^{ix} Specifically, the symptom clusters fail to represent certain complexities of the encounter with mental disorder which are neither immediately observable nor readily measurable. In a mental disorder experience, the individual’s relationship with herself, her physical environment, and her social environment is strained or severed, adding many layers of complexities to the encounter with mental disorders. These include the developmental trajectory of mental disorder in the individual from childhood to adulthood; the individual’s particular life history; interpersonal relationships; biological and environmental risk factors; gender, race, class, and status; the first-person-specific dimension of the symptoms, such as what the individual hears when she hears voices; and the meaning the individual ascribes to these elements of life in her socio-cultural context. Philosopher and psychiatrist John Sadler has called this feature of the DSM “hyponarrativity,” which means that the disorder category is abstracted from particular experiences, contingencies of the individual patient and her social context.^x As discussed in detail below, the DSM categories, by virtue of highlighting symptoms, abstract (or bracket) the self-related and context-specific aspects of the

encounter with mental disorders.^{xi} By saying little about how the disorder experience is integrated into the patient's life as a whole, the categories are simply a "repertoire of behaviour."^{xii}

In the scientific research of mental disorders this sort of abstraction is necessary in order to isolate particular disorder signs and symptoms for study. Bracketing the narrative elements of the disorder experience is thus not a limitation but an essential feature of the scientific study of mental disorders. Likewise, generalization is necessary for the administration of medical practice, notably in coding and billing. We thus limit the scope of this paper to the DSM's limitations in clinical practice, defined here as the one-on-one diagnostic and treatment encounters between medical practitioners and patients. In this description of clinical practice, medical practitioners include (but are not limited to) nurse practitioners, physician assistants, family doctors and psychiatrists. We highlight the hyponarrativity of the DSM-5 in two cases: complicated grief and Post Traumatic Stress Disorder (PTSD). More specifically, we argue the DSM-5 has limitations stemming from this hyponarrativity in the development of effective psychotherapy methods because it abstracts away the important features of individual experiences, and these may be crucial for the clinician to acknowledge and engage with, if he is to restore the patient's relationship to herself and her social and physical world, thereby achieving therapeutic improvement.

3. Complicated Grief

Grief is a complex emotional, physical, cognitive, behavioural, and social response to the loss of someone with whom a meaningful connection has been established.^{xiii} Grief is a ubiquitous human experience, but takes many shapes. Some feel the pain of loss intensely at

first, grieve for a period of time, and then gradually adjust. Some welcome support from friends, relatives, or religious advisors; others rely on their own cognitive and emotional resources. A few may feel stuck in grief, even though a significant period of time has passed and they have received various kinds of support. These individuals may consult clinicians for assistance. This is termed “complicated” or “prolonged” grief by medical practitioners and is the focus of this section.

The DSM-5 enables a clinician to diagnose an individual encountering complicated grief as having major depressive disorder (henceforth depression).^{xiv} This is because, arguably, there are significant overlaps between symptoms and signs of depression, and the experiences of those experiencing complicated grief. In our view, folding complicated grief into depression does not facilitate the development of psychotherapeutic approaches to clinically address complicated grief. This is problematic, we argue, because the DSM manual is intended to be used to further research in mental disorder etiology and also to guide clinical treatment and psychopathology education.^{xv}

We start with an overview of the characteristics of complicated grief: mourning the deceased, mourning the self, and mourning the lost relationship. We then consider the evolution of scientific psychiatry’s approach to complicated grief, and point out the disjunction between complicated grief experience and its symptom-based individuation in the DSM. Then, citing evidence of the effectiveness of psychotherapeutic interventions in addressing grief, we discuss why the DSM-5’s characterization of grief does not provide resources for the development of such interventions.

3.1 Characteristics of Complicated Grief

Complicated or prolonged grief is marked by a pattern of persistent and elevated distress following a loss.^{xvi} It includes mourning (i) the deceased, (ii) the self, and (iii) the sudden loss of a significant relationship.^{xvii}

(i) First, the individual will be distressed about the loss of an inherently and independently valuable person who can no longer participate in life or complete his planned projects. Let us call this the other-related aspect of grief. The individual experiences intense longing and yearning for the deceased; her daily life is interrupted by intrusive thoughts and images involving, for instance, something the deceased had said prior to his death, or the death scene itself. Further, she may avoid places and situations that remind her of the deceased or react excessively to cues that evoke him.^{xviii} To escape these experiences, the individual must recognize and negotiate the fact that the deceased will not be returning and his projects will remain incomplete.

(ii) Second, the individual mourns the loss of a significant aspect of herself. Let us call this the self-related aspect of grief. As philosophers and psychologists have long argued, the self is not an autonomous entity disengaged from its social, and cultural world, but an intersubjective entity constituted by and defined in its relationships to others.^{xix} This means that, as Lorraine Code puts it, persons are “second persons” who only become persons in relation with others.^{xx} This posits both a causal and constitutional relationship between the self and others. Causally speaking, others influence what becomes of the self when one is exposed to different acculturations and social contexts. For instance, the individual can form an identity as a soccer player in contexts where she develops her skills as a soccer player. Among other things, she will need a coach and a group to practice with, and a cultural context where such practice is recognized and respected. Another causal example is the development of self-regarding attitudes;

for instance, self-respect is typically gained and sustained in ongoing and mutually supportive interpersonal relations.^{xxi} The individual's sex, gender, age, race, and class are important as well, as they all have a direct causal influence on what she becomes. Individuals are also constitutionally relational/inter-subjective because their identities include elements of the social context in which they are embedded. For instance, the identity of a person as an immigrant is constituted in a context where she is eligible to live in a country she is not born in.

Considered within a relational framework, then, grieving the loss of a loved one involves grieving for a lost part of the self. As William James suggests, a person's self includes "not only his body and his psychic powers, but... his wife and children, his ancestors and friends... and if they dwindle and die away, he feels cast down."^{xxii} The individual loses some of the self-regarding attitudes generated by the loved one. For example, her self-concept as a daughter changes when her father is no longer alive. The grieving individual feels a sense of emptiness or emotional numbness following loss, possibly experiencing self-directed anger or guilt related to the loss and lacking life aspirations.^{xxiii} She stops engaging with previously enjoyed activities. The more the individual's identity is enmeshed with the deceased, the more difficult it will be to adjust to the loss and redesign her life. She must salvage her identity and continue without the loved one in her life.

(iii) Finally, complicated grief includes mourning the loss of a valuable relationship. The relationship-related aspect of grief is expressed in various forms. For instance, the individual may avoid being in environments where she and the deceased enjoyed joint activities (e.g., tennis courts). An adolescent who loses his father with whom he had a strong relationship may have difficulty connecting to other members of his family and may avoid being in spaces with others. A middle-aged woman who mourns the death of her abusive husband may have to revisit and

cope with abuse related issues before she can accept and cope with the death itself. In all these relationship related issues, closure is recommended for the individual to move forward.^{xxiv}

3.2 Scientific Psychiatry and the Bereavement Exclusion

Complicated grief has long puzzled medical practitioners. It has been a challenge to develop a standardized therapeutic approach because of the cultural, social, and individual diversities in how grief is encountered; but since the late 1970s, the creators of the DSM have entertained the possibility that complicated grief may be individuated as a distinct disease category. Under DSM's descriptive framework, significant similarities are evident between the observable experiences of complicated grief and the symptoms and signs of depression, including sadness, sleep disruptions, changes in appetite, fatigue, diminished interest or pleasure in previously enjoyed activities, and difficulties in concentration, giving birth to the idea that complicated grief can be individuated as a kind of depression.^{xxv} At this point, the remaining challenge for medical practitioners was to distinguish the cases in which experiences of grieving individuals were within the range of appropriate responses to loss from those in which individuals were experiencing complicated grief, a precursor to fully developed depression.

To avoid a possible false positive problem in the clinical context, where the distress associated with appropriate grief could yield a misdiagnosis of the grieving individual's condition as depression, the psychiatric community introduced the bereavement exclusion criterion into the depression diagnostic criteria.^{xxvi} More specifically, the DSM-III stated that if the depression-like symptoms of the individual in grief exceeded *one year*, a depression diagnosis could be made and the individual could receive appropriate treatment. In the DSM-IV, the length of appropriate grieving was reduced to *two months*. In the DSM-5, the bereavement

exclusion criterion has been removed, based on the assumption that grief related distress and depression are *not* distinct. Clinicians can now diagnose individuals with depression if their grief is manifest in experiences resembling the symptoms of depression, as early as two weeks after the loss – the required time for those with depression symptoms to receive a clinical diagnosis.

The rationale for removing the bereavement exclusion is that there is no scientific evidence for characterizing bereavement related distress and depression as distinct conditions; hence, whatever treatment helps the latter will also help the former.^{xxvii} Proponents of this change in the DSM-5 further argue that if those struggling with grief are not diagnosed with depression, they will not receive clinical support even if they need it. The Chair of the DSM-5 Task Force, psychiatrist David Kupfer, argues that without the change, a person suffering from severe depression symptoms one or two months after a loss can't be diagnosed as depressed and “may then not get the treatment they need.”^{xxviii} Some even propose an increased risk of suicide among those suffering from bereavement-related distress and highlight the importance of early intervention.^{xxix}

Now consider the DSM-5's individuation of major depression, which, with the removal of the bereavement exclusion criterion, is expected to guide the clinician to address complicated grief. According to the depression criteria listed in it, at least five symptoms have to be present during a two-week period and must represent a change from the patient's previous functioning: either “depressed mood” or “diminished interest in and pleasure from daily activities” must be among the five. Additional symptoms include: significant weight loss or gain; insomnia or hypersomnia; psychomotor agitation; fatigue or loss of energy; feelings of worthlessness or inappropriate guilt; diminished ability to think or concentrate, indecisiveness, recurrent thoughts of death, and suicidal ideation.^{xxx} To prevent misdiagnosis, if the symptoms are accounted for by

the direct physiological effects of a substance or a general medical condition, a depression diagnosis cannot be made.^{xxxii} As of yet we have not noticed any research conducted on whether the removal of bereavement exclusion has caused an increase in depression diagnosis and treatment, however, it would be interesting and important to pursue such investigation.

3.3 Major Depression as a Construct for Complicated Grief

Simply stated, while an individual with complicated grief may manifest depressive symptoms, engaging with and addressing these symptoms alone will not automatically remedy the distressing feelings involved in her loss (i.e., mourning the deceased, the self, and the relationship). The DSM-5 framework, by directing the clinician's attention to managing symptoms individually, as opposed to engaging with the three aspects of grief simultaneously, fails to offer resources likely to address complicated grief. We can easily imagine scenarios in which the overworked family doctor, within the 15 minutes allotted for each patient, may diagnose a grieving individual with depression, basing his diagnosis on the similarity of the complaints to the symptoms of depression and failing to recognize that the underlying stressor of those complaints is the loss of a loved one.

Thus, by slotting grief under depression, the DSM-5 erases the therapeutic import of distinguishing the two. It does not actively guide the clinician to engage with the personal details of the individual's particular loss. In addition, given that the DSMs are used for teaching purposes in medical schools, the more symptom-oriented the mental disorder descriptions are, the less likely it will be for psychiatry residents to receive special training in psychotherapy and other narrative treatment techniques, as the symptom-management approach lends itself naturally to a medication-based treatment strategy.

3.4 Psychotherapeutic Approaches to Complicated Grief

Interestingly, some psychotherapeutic approaches effectively address complicated grief by targeting the self, the deceased, and the relationship-related aspects of grief. For example, cognitive-behavioral therapy and interpersonal therapy techniques are efficacious in ameliorating the symptoms of prolonged grief, especially for those experiencing heightened distress following loss.^{xxxii} The common denominator of these therapies is targeting the above mentioned aspects of grief and addressing the needs stemming from these dimensions. In such psychotherapeutic approaches, the primary goals are to establish a strong therapeutic alliance with the grieving individual, to obtain a history of her interpersonal relationships and interpersonal history, including early family relationships, other losses, her relationship with the deceased, the story of the death, and current relationships. The therapist and individual discuss the latter's current life situation, including stressors and coping resources.

In the self-related aspect of grief, the age, race, and gender of the griever, as well as the level of distress encountered, are important determinants of psychotherapeutic treatment. With small children, for instance, psychotherapy tends to focus on understanding and highlighting the place and meaning of the deceased individual in the child's life and asks whether the child has other individuals in her life who might give her similar support. The therapist tries to understand the child as an individual, seeking to identify her dreams, aspirations and support system; she develops an approach that suits these needs. In building a therapeutic alliance with the child, the therapist earns the child's trust and helps her create a different kind of relationship with the deceased. The treatment also involves focusing on the child's personal goals and relationships.^{xxxiii} Early intervention is associated with greater efficacy.^{xxxiv}

For the other-related and relationship-related aspects of grief, most methods employ some form of cognitive restructuring and exposure. Cognitive restructuring techniques help the griever come to terms with the death of the deceased, for instance, following suicide, and to revise her understanding of him. Exposure techniques typically involve retelling the story of the loss or confronting avoidance of places or people associated with the loss. The interventions target both the experience of loss (using exposure and restructuring techniques) and restorative processes (goal setting and improved relationships).^{xxxv} While some of these treatment strategies (e.g., goal setting) are also used in depression, methods such as exposure and restructuring are used exclusively to treat patients who encountered grief and/or traumatic event. Hence, it is not correct to assume that treatment strategies effective in depression are also effective in addressing grief.

4. Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) has a complicated social and scientific history. As we will discuss below, the inclusion of PTSD in the DSM-III in 1980 was motivated and complicated by political concerns surrounding a diverse community of trauma survivors. Scientifically, PTSD is one of the disorder symptom-clusters in the DSM that retains an etiological descriptor in addition to symptom and sign descriptions.^{xxxvi} More specifically, the PTSD diagnosis requires the existence of a traumatic stressor (either a singular traumatic event, or exposure to trauma consistently over time), which is deemed to be the cause of the symptoms of intrusion, avoidance, negative alterations in cognition or mood, and hyperarousal.^{xxxvii} PTSD is a complicated diagnostic category for several reasons. First, quality of the traumatic stressor varies by individual such that after experiencing the same event, one person can develop PTSD

symptoms while another does not. For example, suppose two persons are involved in an automobile accident, and further suppose that the first individual had suffered the loss of her father from a car accident during her youth and the second has no trauma associated with automobiles. The first person could develop PTSD symptoms as a result of the event while the second may not. This points to, as we discuss below, the fact that for an event to be traumatic for an individual, elements of the individual's history, psychology, and social location are important. Second, the symptoms of avoidance and negative alterations in cognition and mood may be present prior to traumatic exposure for members of groups who face social threat situations of violence more than others.^{xxxviii} As we explain below, women, people of color, LGBTQ and trans persons face violence and the threat of violence at higher rates than others, and thus have different orientations to the social world even absent exposure to a traumatic event personally.

In this section, we show that the self-related and gender-related dimensions of trauma experience are missing in the diagnostic criteria for PTSD. The DSM-5 does acknowledge that females are more likely to experience PTSD than males due to greater exposure to rape and interpersonal violence, but it leaves unrecognized the importance of the context in which individuals experience violence and the factors that contribute to individuals' defining a particular action or event as violence. When trauma is addressed clinically, however, the therapist must recognize and engage with these details. Thus, the DSM-5 does not provide useful resources for the therapeutic addressing of PTSD.

4.1 Evolution of PTSD in the DSM

The current understanding of psychological trauma and PTSD is rooted in late nineteenth-century psychological typing of hysteria and early twentieth-century studies of World

War I combat survivors.^{xxxix} The first scientific study of hysteria was conducted in the late nineteenth century, by Jean-Martin Charcot, who documented what appeared to him as neurological symptoms: motor paralysis, sensory losses, convulsions and amnesia.^{xl} Twenty years later, Pierre Janet and Sigmund Freud (working separately) found the neurological responses catalogued by Charcot were caused by underlying psychological trauma, which, when triggered, produced an altered state of consciousness—“dissociation” for Janet and “double consciousness” for Freud—which, in turn, resulted in the neurological symptoms catalogued by Charcot. Following the First World War, it was noted that returning soldiers began to “act like hysterical women”: weeping uncontrollably, experiencing dissociation, aphasia, memory loss and emotional numbness.

Although the similarities between the symptoms and signs of hysteria and the experiences of combat veterans were significant and striking, there was resistance to associating “brave” combat veterans with “hysterical women.” One response was the valorization of those who did not suffer psychological trauma after combat: simply stated, soldiers of strong moral character did not experience the aftermath of war in this way. Accordingly, those who did were diagnostically grouped with women with hysteria and thought to have weak moral character. After the Second World War, the thinking changed; veterans suffering psychological trauma related to combat exposure were dissociated from hysterical women. Military psychiatrists found that *any* man could suffer psychological trauma in proportion to the severity of exposure to combat, and “combat neurosis” became a legitimate and predictable effect of combat exposure. Systematic, large-scale investigations of combat neurosis and its long-term psychological effects began after the Vietnam War.^{xli} Vietnam veterans were at the forefront of a social movement that brought unprecedented scientific attention to the psychological trauma of

combat. For example, they organized “rap groups” that offered solace to those suffering psychological trauma and raised awareness about the psychological effects of war. The movement was taken up by the Veteran’s Administration, which commissioned a comprehensive study on the long-term effects of combat exposure. These efforts brought this type of trauma to the attention of the medical profession. In 1980, for the first time, Post Traumatic Stress Disorder (PTSD) was individuated through a symptom and sign cluster and entered the DSM-III as a mental disorder.

4.2 The Limitations of The Stressor Criterion

In the DSM-5, PTSD is recategorized as a trauma- or stressor-related disorder rather than an anxiety or fear disorder.^{xlii} This new categorization affirms the importance of the traumatic event or traumatic exposure as an etiological instigator of the symptoms that follow: intrusion, avoidance, negative alterations in cognition or mood, and hyperarousal. We argue that traumatic exposure, as described in the DSM-5, limits the understanding of PTSD because it primarily requires the existence of (i) the traumatic stressor(s) themselves, however neglects (ii) the narrative elements of the self that contribute to an individual experiencing an event as traumatic, which lead to the unique presentation of the PTSD symptoms in individual sufferers. Given that the DSM criteria guide not only the diagnostic process but also the treatment process, we believe that it is crucial to engage with (ii), as these have therapeutic import in the clinic.

Consider the stressor criterion (traumatic exposure) that underlies the etiology of PTSD:

“A: Exposure to actual or threatened death, serious injury, sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others.

3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).^{xliii}

In addition to being the victim or intended victim of violence, assault, or injury, witnessing an event, learning of an event, and repeated exposure to the aftermath of traumatic events are included as putative causes. Some suggest the broader scope could weaken PTSD as a viable diagnostic category.^{xliv} Our concern here is not the broadness of the exposure criterion but the oversight of the recognition of (ii) the narrative elements of the self that contribute to an individual experiencing an event as traumatic. The characteristics of a traumatic event have less to do with PTSD symptom presentation than do the psychological characteristics of the individual and her sensitivity, or vulnerability to trauma.

Recall the example of the automobile accident mentioned above: the person who had suffered an important loss as a result of an automobile accident is more likely to experience acute stress disorder or PTSD as a result of an automobile accident than a companion who had not suffered such a loss. The former may experience intrusive memories of the prior loss as well as the more recent automobile accident; she may avoid traveling by automobile or bus, and areas surrounding the event of the accident and even those resembling the area of the accident; she may experience new or renewed fears or anxieties or hopelessness; and she may experience heightened arousal at the sights or sounds of an automobile backfiring, glass shattering, etc. The companion, on the other hand, may react so that she is more aware or vigilant while driving in the future, may suffer acute stress reactions, and even avoid travelling by road, but she is less likely to experience the range and severity of trauma symptoms as is the first, even if she develops PTSD.^{xlv} In short, the first person is already more vulnerable than the companion, and

so the threat of death or injury is experienced more acutely, therefore, more traumatically. In addressing the needs of these two individuals who suffer from PTSD, the clinician will have to pay attention to, and engage with their unique responses, which cannot be isolated from their own individual stories and social contexts. As we indicate above and reiterate in the conclusion, these individual stories and social contexts are absent from the DSM-5 and because the DSM-5 is used at least in part as a primary teaching tool for clinicians, sensitivity to such stories and contexts may not be developed in clinicians without more extensive psychiatric training.

4.3. The Limitations in the Individuation of “Violence”

We also argue that the concept of “violence” used in the DSM-5 does not recognize violence as a relational phenomenon, nor the social factors that contribute to and create the background conditions for violence. As we will describe below, some group memberships (e.g., gender-based) make one more vulnerable to violence, and this shapes the victim’s perception of violence as a socially embedded and embodied person.^{xlvi} Acknowledging, and engaging with the individual’s social embeddedness and embodiment, which help to constitute the particular meaning of being subject to violence, however, are important for therapeutic improvement in the clinic, and thus must be acknowledged in the DSM, if it is to educate and guide clinicians.

“Violence” is not explicitly defined in the DSM-5; it is rather used as a generic concept. The concept is intrinsically layered, however, as much philosophical work shows.^{xlvii} The DSM-5’s neglect of these layers make it a poor guide for PTSD treatment. Philosophers have argued that the concept of violence is, at its core, physical,^{xlviii} and rests on related notions of force and aggression.^{xlix} Many of these arguments take as a central concern what counts as *real* violence over and above what is merely harm or aggression; importantly, they seek to protect the term’s

meaningfulness from metaphorical and allegorical extensions that threaten its clarity. The DSM-5's individuation of violence represents what Vittorio Bufacchi calls a "minimal" conception of violence, because it sets the minimum requirements for an act or event to be defined as a violent one.ⁱ The problem with a minimal conception of violence is that it misses the social and political dimension of our thinking about violence; in particular, it misses that violence describes a social relationship rather than simply an act or an event.ⁱⁱ The social relationship of particular interest is the power relationship between violent actors and their victims. This points to the position of vulnerability in which many persons find themselves by virtue of their group membership.ⁱⁱⁱ

What is problematic about the absence of a relational account of violence and trauma in the DSM-5 is the consequent failure to recognize the psychological and behavioral effects of vulnerability. For instance, Criterion C in the DSM-5's PTSD category requires that traumatic exposure or violence cause avoidance of triggering places, persons or things.ⁱⁱⁱⁱ We are concerned with the clean temporal order assumed in the connection between the violent event and individual's future reactions. It presumes the social world is neutral for each individual, and the traumatic event causes a change in that social world such that some spaces are "safe" and others are "dangerous." This must happen in many cases, but persons whose group membership makes them more vulnerable to violence may not experience the world as neutral from the outset. Ann Cudd argues that the prevalence of violence based on group membership creates "social threat situations" for members of targeted groups.^{liv} Living in a social threat situation decreases mobility, increases feelings of disempowerment and reinforces social power dynamics that produce vulnerability, violence and traumatic exposure.

Criterion D is similar in that it requires that traumatic exposure or violence cause a change in cognition and mood, most notably manifesting in negative beliefs and emotional

states, as well as alienation from social life.^{lv} The same modifications in behavior experienced in social threat situations may already exist for persons living in asymmetrical power relationships as a result of their social location.

4.4 Gender and PTSD

A significant and overlooked aspect of the self in PTSD is gender location. Gender location is absent in the DSMs generally and PTSD classification specifically in two important ways. First, the DSMs assume a normal course of psychological development and a normal relationship to the world in order to describe disordered or abnormal states or responses. The assumed normal relationship to the self and world is historically and stereotypically masculinist, while typically feminine traits such as interdependence, emotion, and anxiety are considered as signs of abnormality.^{lvi} As Nancy Potter notes, sexual development is an important factor in the course of psychological and embodied development; and thus in mental health.^{lvii} For instance, young girls' sexual development is different than young boys, and young girls often experience their bodies and selves as ambiguous, paradoxical and discontinuous. These are important factors in understanding the individual in the clinical context, however, they are not regarded as important factors contributing to the individual's mental health.

Second, vulnerability to traumatic stressors and inculcated sensitivity to trauma are directly related to the individual's social location, specifically, gender, sexual and racial location. As we know, women are more vulnerable to sexual violence than men, and trans persons are more vulnerable to violence than other queer populations. A 2010 Centers for Disease Control Report^{lviii} estimates that 1 in 6 women experience stalking at some point in their lives in which they felt fearful or believed that they or someone close to them would be harmed or killed, while

1 in 10 men experienced the same. It is estimated that 1 in 3 women in the United States is a victim of intimate partner violence (IPV) while 1 in 10 men is a victim of IPV. Within the latter category, 1 in 2 American Indian or Alaskan Native men is a victim of IPV and 2 of 5 Black or non-Hispanic minority men are victims. The National Coalition of Anti-violence Programs (NCAVP) reports that while hate violence in general has decreased, violence against members of the LGBTQH community has increased by 11%. Of those targeted, 87% were people of color, and those who identify as transgender were 28% more likely to experience physical violence than those who are gender/sex/sexuality normative.^{lix}

Persons with these group memberships learn to be sensitive to their surroundings; they learn how to avoid situations that might provoke violence, and in the case of women, they often present in their bodily comportment signs of weakness and submissiveness to avoid aggressive confrontations. Women sit with their legs and arms crossed and heads down in public settings, they walk close to buildings rather than street-side on sidewalks, and they alter their speech to avoid aggression.^{lx} In addition, an individual's gendered social location may cause him/her to perceive as violent (or potentially violent), and therefore traumatic, events or situations that a person at a different gender location may not. Similar to the example of the two persons experiencing the automobile accident above, two persons with different gender, sex or sexual locations and history may experience the same event differently. While a white, cis-gendered male may take cat-calling from the street as a compliment or shrug it off, a woman or trans person who is aware of her/his gendered or sexualized vulnerability may experience it as a threat to her/his safety.

In sum, as discussed in sections 4.2., 4.3., and 4.4., the DSM-5 criteria for PTSD suffer from hyponarrativity in the absence of attention to socially significant aspects identity that

influence how or whether an individual experiences events as traumatic, which particular aspects of their cognition, mood or behavior are altered and how significant these are to the individual herself. As we have noted here in the case of PTSD, specifically gendered components of a person's life may complicate both diagnosis and treatment. To deploy the stressor criterion usefully in diagnostic and clinical practice, these self-related and context specific factors must be considered. In addition to the complexity of the cognitive structure of the *self*, clinicians must understand the social and political conditions of sexism, racism, homophobia and heteronormativity that create social threat situations, that influence behavior and self-concept, and that contribute to the likelihood of victimization in order work through, with a patient, the traumatic stressor and PTSD symptoms.

4. 5. Psychotherapeutic Approaches to PTSD: Trust and Agency

Certain psychotherapeutic approaches engage with the complex dimensions of trauma experienced by the individual and are shown to be effective in addressing PTSD. It is widely agreed that cognitive behavior therapy (CBT) is the most effective treatment for post-traumatic stress disorder.^{lxi} Effective forms of CBT include psychoeducation, anxiety management, exposure therapy and cognitive restructuring.^{lxii} Scholars have also noted the importance of the psychotherapist-patient relationship in treatment.^{lxiii} Trust is important for both the patient and psychotherapist, as a central component of PTSD is disconnection from others, identified in the DSM-5's criterion D.6 as "detachment" and "estrangement".^{lxiv} Trust is an issue in all trauma and trauma-based psychotherapy because the basic capacities for trust are diminished by traumatic exposure and in many instances of trauma, especially sexual violation and childhood trauma, dominance and submission are central features of the traumatic event.^{lxv} Loss of trust in

others and detachment from others are roadblocks to effective PTSD treatment because for psychotherapeutic treatments such as CBT to be effective, the psychotherapist needs important information about the patient's life, the traumatic event and cultural information to determine the necessity, scope and dosage for psychotherapeutic treatments.^{lxvi} Further complicating the effectiveness of CBT treatment in PTSD, a patient's socioeconomic class and education level are related to a better therapeutic outcome.^{lxvii} It is established that a psychotherapist must be sensitive to these self-related and context specific factors in the patient's life, which can only be gleaned in the context of a strong interpersonal relationship that is itself difficult for a trauma patient to enter into.

Thus, the first essential component of treatment for trauma is a healing relationship of trust.^{lxviii} First, the relationship itself represents a type of treatment or healing because trauma victims overwhelmingly experience estrangement and detachment from others. Second, some of the basic capacities for interpersonal relationships – trust, autonomy, initiative, identity and intimacy – are first formed in relationships, and so must be reformed in relationships post-trauma.^{lxix} Therapists ought to see psychotherapy as a “cooperative relationship” with clients, an arrangement characterized by sharing, wherein therapists recognize the importance and limitations of their role and specialized knowledge so that the client can share the narrative aspects of his or her life that are essential to effective treatment and recovery.

Interestingly, these empirical findings in psychology and psychiatry converge with the core arguments developed in feminist scholarship. Feminist philosophers have argued that re-focusing on the relational elements of the self, and indeed the relational formation of the self, is central to the study and understanding of trauma. In particular, they highlight the importance of others in the recovery process. The therapeutic recovery process must work through the

recognition of the involuntariness of trauma and resultant feelings of lost control.^{lxx} Intrusive memories are experienced involuntarily *and* carry content of extreme vulnerability and possibly control by another. They are double reminders of the victim's vulnerability and powerlessness in relation to others. Re-telling traumatic memories, when they are available, can help victims gain more control over "the traces left by trauma."^{lxxi} Susan Brison expresses it succinctly when she writes:

Narrative memory is not passively endured; rather, it is an act on the part of the narrator, a speech act that defuses traumatic memory, giving shape and a temporal order to the events recalled, establishing more control over their recalling, and helping the survivor to remake the self" (71).

Voluntariness counters involuntariness when an individual constructs and gives her narrative to another. In this case, the psychotherapist can be a site for voluntary retellings. Imagined others can also receive the narrative. Research indicates the therapeutic effectiveness of programmed writing, diaries, journaling, autobiography, storytelling, and poetry in psychotherapy in the wake of trauma.^{lxxii} The real or figurative presence of an other externalizes the narrative which, according to Brison, "temporarily split[s] the self into an active—narrating—subject and a more passive—described—object."^{lxxiii}

At stake here is the trauma survivor's sense of her own agency or power in the world. Agency and the social compilations of agency tied to the self are not addressed in the DSM-5's PTSD criteria, most likely because agency cannot be operationalized scientifically. Agency, however, is a central feature of human life. It can be encouraged in some and diminished in others by social forces, and an individual's sense of her own agency can change as a result of traumatic exposure. The involuntariness of the traumatic event itself, the intrusion of traumatic memories and unanticipated dissociative states can all cause a trauma victim to question her agency or autonomy.

In feminist philosophy, agency has undergone a radical reconceptualization from a self-centric model to a relational one.^{lxxiv} An individual's group memberships, cultural traditions and personal history all leverage her ability to exercise agency because her sense of what is possible is connected to how she defines and views herself in relation to others.^{lxxv} Apart from particular traumatic events, persons living in asymmetrical power relationships based on their group membership, e.g., women in patriarchal societies, people of color in racist communities, suffer what Hilde Nelson calls "damaged identities." Like Brison, Nelson argues the repair of the damaged self occurs through narrative reconstruction. There is a social connection between this philosophical theory of damaged identities and the psychological description of PTSD in the DSM-5: the group memberships that make individuals vulnerable to violence and traumatic exposure are the same memberships that damage identities and therefore agency. Nelson proposes the deliberate creation of counter-stories to alter a sub-group member's self-perception as well as the perception of sub-group members in general by a dominant group. The act of the counter-story repairs damaged identity because confronting and challenging a dominant narrative is a "purposive act of moral definition."^{lxxvi}

Trust and agency are important aspects of the self, and the recovery from mental disorder, aspects on which the DSM is silent. They are interwoven with the individual's social location: race, gender, class, education level, physical ability, nationality, etc. Because they evade scientific classification, they require special attention in psychotherapeutic relationships.

5. Conclusion

Our goal in this article has been to identify the context-specific limitations of the DSM-5's diagnostic criteria in the clinical setting. We isolate this aspect of the DSM-5's use because it

is a manual that is used for a variety of purposes: insurance coding, scientific research, clinical education and treatment development. It is in these last two purposes that the hyponarrativity of the DSM-5 can be most problematic. As the examples of complicated grief and post-traumatic stress disorder illuminate, the hyponarrativity of the DSM-5's disorder categories limits its usefulness in identifying and therefore treating some disorders. In particular, we have shown that the development of effective psychotherapeutic treatments for the complicated grief and post-traumatic stress disorder requires special attention to the social, cultural and self-related features of these disorders.

There is no scarcity of protest against the DSMs in scholarship, and we do not intend to add to this protest. Identifying the limitations of the DSM-5 stemming from hyponarrativity opens the door for recommendations that amplify the strengths of the DSM-5 at the same time as remedying these limitations.

First, medical practitioners in general must be careful to place the DSM-5's operationalized disorder categories into the larger context of a patient's life. They must recognize that individuals, even those with mental disorder, are cognitively complex, meaning making beings, who respond, for better or for worse, to the language and narratives in which they are situated. As we demonstrate in the examples of grief and post-traumatic stress disorder, the narrative elements of an individual's life influence her mental disorder experience and are sometimes the key elements of her life that psychotherapy aims to repair. While psychologists and psychiatrists are well-trained in contextual interviewing and the complexities of mental disorders, family practice physicians, nurse practitioners and physicians' assistants may lack such training absent a specific focus in psychiatry. This is an important lacuna in the integration of psychiatric care with health care, as the latter set of medical practitioners serve on the front

lines of identifying patients with symptom clusters of mental disorder for referral to psychiatric specialists and many may lack the training necessary to use the DSM-5 in a resourceful way.

Second, the larger community of psychiatric practitioners must advocate for more time with patients, time during which more complex patient histories can be gathered and the narrative contexts of mental disorder can be explored in relation to the DSM disorder categories. This will draw on the strengths of the DSM-5 as a research tool for the classification and study of mental disorders while at the same time allow for more complex and nuanced use of disorder categories in the diagnosis and treatment of individuals with mental disorders.

Third, mental health professionals must continue to initiate and remain in important dialogues of inquiry not only with neuroscientists and geneticists, but also anthropologists, social workers, historians, psychologists, and philosophers. The DSM is a research and clinical tool whose influence extends beyond the bounds of the psychiatric profession itself. It is used in research in cognitive science, social theory, philosophy and area studies such as feminist theory, critical race theory and disability studies. The writers of the DSM and psychiatric professionals generally ought to remain in dialogue with researchers in these fields, and where dialogue is strained, researchers must work together to investigate, from multiple angles and scientific methodologies, shared points of inquiry.^{lxxvii}

Finally, more emphasis must be given on the development of professional virtues for mental health practitioners. Some of these virtues include, trustworthiness, humble propriety, gender sensitive virtues, empathy (and compassion), warmth, self-knowledge, emotional intelligence, and integrity, hopeful patience, and perseverance, respect for the patient and for the healing project, moral integrity, sincerity and wholeheartedness.^{lxxviii}

There is scientific, psychological and social power in the naming and description of psychological disorders and individual responses to these.^{lxxix} Psychiatric taxonomy is not just a project of ‘carving the nature at its joints,’ but also an ethical project of identifying the ways in which mental health care can best contribute to the flourishing of individuals with mental disorders. Psychiatric professionals must thus cultivate awareness of the DSM’s power and its potential effects on research, patient mental health and the perception of mental disorder by patients and their communities. Included in this should be a concern for the first-person stories, narratives, and memoirs that address the self-related and context specific factors of individuals’ experience with mental disorder and their therapeutic recovery. These are some of the important elements that contribute to the success of psychotherapeutic recovery for patients and factors that will aid practitioners in their own clinical development as well as the development of effective therapies for patients. These are also important resources that must be used as educational tools in medical schools and psychiatric residency and training programs.

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ⁱ American Psychiatric Association, *Diagnostic and Statistical Manual: Mental Disorders, 4th Edition* (1994): xxiii (hereafter *DSM-IV*); APA, *Diagnostic and Statistical Manual: Mental Disorders, 5th Edition* (2013): xli (hereafter *DSM-5*).

ⁱⁱ Sokal, "Classification: Purposes, principles, progress, prospects."

ⁱⁱⁱ APA, *Diagnostic and Statistical Manual: Mental Disorders: 1st Edition* (1952), hereafter *DSM-I*.

^{iv} Robins and Guze, "Establishment of diagnostic validity in psychiatric illness"; First, Pincus, Levine, et al., "Clinical Utility as a Criterion for Revising Psychiatric Diagnoses."

^v Sadler, *Values and Psychiatric Diagnosis*; Radden, *Moody Minds Distempered*; and Tekin, "Psychiatric Taxonomy: At the crossroads of science and ethics."

^{vi} Pearce, "DSM-5 and the rise of the diagnostic checklist." It is worth mentioning that once a genetic substrate is discovered, a disorder is removed, such as Rett's Syndrome.

^{vii} Radden, *Moody Minds*, 79.

^{viii} APA, *Diagnostic and Statistical Manual: Mental Disorders, 3rd Edition*, 7.

^{ix} Sadler, *Values in Psychiatric Diagnosis*; Tekin, "Psychiatric Taxonomy"; Tekin, "How does the self adjudicate narratives?"; Pearce, "DSM-5 and the rise of the diagnostic checklist."

^x Sadler, *Values in Psychiatric Diagnosis*.

^{xi} Hyponarrative descriptions of disorders can also be seen in other medical fields than psychiatry. For instance, an individual may regard herself only as a woman with breast cancer, isolated and distanced from other aspects of her personal identity, and interpersonal relationships. It is beyond the scope of this paper, however, to consider how

hyponarrativity in such disorder contexts may be resourceful, or to compare it with hyponarrativity in the context of mental disorder.

^{xii} Cohen, *Theory and Practice of Psychiatry*. It should be noted that hyponarrativity is not unique to mental disorder and a similar critique could be applied to physical illnesses or disorders as well. For instance, the cancer patient battles both cancer and strain on her relationships and mental health. We are concerned here only with the hyponarrativity of the DSM's disorder categories.

^{xiii} Grief generating loss includes the death of a loved one, loss of home, property, employment, as well as losses due to a natural disaster. This article discusses only the loss of a loved one.

^{xiv} We do not claim that all those who are grieving must be clinically treated. Rather, those experiencing complicated grief have difficulty coping with their loss on their own and may need clinical assistance. Note: whenever we indicate "grief" or "grief related distress" we are referring to complicated grief.

^{xv} APA, *DSM-4*, xxiii; APA, *DSM-5*, xli.

^{xvi} Bonanno, "Loss, Trauma, and Human Resilience: Have we underestimated the human capacity to thrive after extremely aversive events?" 20-28; Bonanno, Moskowitz, Papa, et al., "Resilience to Loss in Bereaved Spouses, Bereaved Parents, and Bereaved Gay Men."

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^{xviii} Shear, Frank, Houck et al., "Treatment of Complicated Grief: A randomized Control Trial."

^{xix} Relational and intersubjective features of the self have been developed and defended by both feminist philosophers (e.g. Myers, "Intersectional Identity and the authentic Self: Opposites Attract"; Code, *What Can She Know? Feminist Theory and the Construction of Knowledge*; Radden, "Relational Individualism and Feminist Theory"; Nelson, *Damaged Identities, Narrative Repair*), communitarian philosophers, (e.g., Taylor, *Sources of the Self: The Making of the Modern Identity*), as well as psychologists and philosophers of psychology (e.g., Flanagan, *Self-expressions: Mind, morals, and the meaning of life*; Neisser, "Five Kinds of Self-Knowledge"; and Jopling, *Self-knowledge and the Self*). In expanding on the relational/inter-subjective features of the self, we draw on all these literatures.

^{xx} Code, *What Can She Know?*

^{xxi} Flanagan, *Self-expressions*.

^{xxii} James, *Principles of Psychology*, 279-280. James's views are used here to support the idea that we are relational/intersubjective subjects and that losing a loved one is like losing a part of one's self. We do not use this point to make practical recommendations for addressing grief, though what follows is that part of grieving process involves grieving for the self and restoring the sense of loss in the subject. Support shall be provided to engage with this dimension of grieving.

^{xxiii} Shear, Frank, Houck et al., "Treatment of Complicated Grief: A randomized Control Trial."

^{xxiv} Wetherell, "Complicated Grief Therapy as a New Treatment Approach," 159-166.

^{xxv} Horwitz and Wakefield, *The Loss of Sadness: How psychiatry transformed normal sadness into depressive disorder*.

^{xxvi} Wakefield and First, "Validity of the Bereavement Exclusion to Major Depression: Does the empirical evidence support the proposal to eliminate the exclusion in DSM-5?"; Frances, "Last Plea to DSM-5: Save Grief from the Drug Companies."

^{xxvii} Zisook and Kendler, "Is Bereavement-related Depression Different than Non-bereavement-related Depression?"; Zisook, Shuchter, Pedrelli et al., "Bupropion Sustained Release for Bereavement: Results of an open trial"; APA, *DSM-5 Website* (2011). This claim has been challenged by some who suggest that cited evidence is slim (Horwitz and Wakefield, *The Loss of Sadness*; Wakefield and First, "Validity of the Bereavement Exclusion to Major Depression"; Kleinman, "The Art of Medicine: Culture, Bereavement, Psychiatry"; and Frances, "Last Plea to DSM-5." Whether complicated grief and depression are distinct is beyond the scope of this paper; for a detailed discussion, see Tekin, "Against Hyponarrating Grief: Incompatible Research and Treatment Interests in the DSM-5."

^{xxviii} Carey, "Grief Could Join List of Disorders."

^{xxix} Cf. Shear, Simon, Wall et al., "Complicated Grief and Related Bereavement Issues for DSM-5." In a National Public Radio interview, Sidney Zisook said: "I'd rather make the mistake of calling someone depressed who may not be depressed, than missing the diagnosis of depression, not treating it, and having that person kill themselves. See Zisook, "Today in Your Helath: Bereavement," *National Public Radio Morning Edition*, Aug. 2, 2012.

^{xxx} APA, *DSM-5*, 125.

^{xxxi} Until the publication of the DSM-5, bereavement was one of these conditions. See APA, *DSM-IV*, 327.

^{xxxii} Mancini, Griffin and Bonanno, "Recent Trends in the Treatment of Prolonged Grief."

^{xxxiii} Wetherell, “Complicated Grief Therapy”

^{xxxiv} Mancini, Griffin and Bonanno, “Recent Trends in the Treatment of Prolonged Grief”; Currier, Neimeyer, and Berman, “The Effectiveness of Psychotherapeutic Interventions for Bereaved Persons: A comprehensive quantitative review.”

^{xxxv} Wetherell, “Complicated Grief Therapy”; Shear, Frank, Foa et al, “Traumatic Grief Treatment: A pilot study.”

^{xxxvi} Paris, *The Intelligent Clinicians’ Guide to the DSM-5*; Friedman, “PTSD in the DSM-5: Reply to Brewin, Kilpatrick, and Maercker and Perkonig.”

^{xxxvii} APA, *DSM-5*, 271.

^{xxxviii} Cudd, *Theorizing Oppression*.

^{xxxix} Herman, *Trauma and Recovery*.

^{xl} Herman, *Trauma and Recovery*, 20. See also Mary Daly, *Gyn/Ecology*: 227. As Daly recounts, hysteria in women was thought to be a product of sexual deviance or malfunction in women’s sexual organs. In 1873, Dr. Robert Battey began castrating women (oophorectomy) in the attempt to cure what he thought to be insanity.

^{xli} See Lifton, *Home from the War: Vietnam Veterans: Neither Victims nor Executioners* and Egendorf et al, *Legacies of Vietnam*, vols. 1-5.

^{xlii} For a comprehensive account of this change, see Foa, Keane, Friedman and Cohen, *Effective Treatments for PTSD*.

^{xliii} APA, *DSM-5*, 271.

^{xliv} Paris, *The Intelligent Clinician’s Guide*, 126.

^{xlv} Again, this example illustrates that PTSD diagnosis cannot be etiologically isolated. While the companion might suffer stress responses, they are less likely to rise to the level of PTSD because of her individual history.

^{xlvi} Mosko, “Sexualized Violence, Moral Disintegration and Ethical Advocacy,” Ch. 2-3.

^{xlvii} E.g., Audi, “On the Meaning and Justification of Violence”; and Bufacchi, “Why is Violence Bad?”

^{xlviii} Keane, *Reflections on Violence*.

^{xlix} Bäck, “Thinking Clearly about Violence.”

^l Bufacchi, “Why is Violence Bad?”

^{li} Bufacchi, *ibid*; Audi, “On the Meaning and Justification of Violence.”

^{lii} The cases of traumatic exposure not etiologically tied to agents or collective agency escape this criticism, as these philosophers are more concerned with interpersonal violence. It is also worth noting that violent actors can experience trauma, as is well documented in military context. Cf. Nancy Sherman, *The Untold War*.

^{liii} The *DSM-5* reads: “C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s),” 271.

^{liv} Cudd, *Analyzing Oppression*.

^{lv} The *DSM-5* reads: “D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and no to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings),” 271-72.

^{lvi} Sadler, *Values and Psychiatric Diagnosis*, Potter, “Gender” in *The Philosophy of Psychiatry*, Kaplan, “A Woman’s View of DSM-III.”

^{lvii} Potter, “Gender,” 240.

^{lviii} <http://www.cdc.gov/violenceprevention/sexualviolence/>

^{lix} <http://www.glaad.org/blog/violence-against-transgender-people-and-people-color-disproportionately-high-lgbtqh-murder-rate>

^{lx} Young, “Throwing Like a Girl: A phenomenology of feminine bodily comportment” and “Lived Body vs. Gender: Reflections on social structure and subjectivity”; Bartky, *Femininity and Domination*.

^{lxi} Diehle et al., “Effects of Psychotherapy on Trauma-related Cognitions in PTSD: a meta-analysis”; Frommberger et al., “Posttraumatic Stress Disorder: A diagnostic and therapeutic challenge”; Institute of Medicine of the National Academies *Treatment of Posttraumatic Stress Disorder: An assessment of the Evidence*. (Washington, D.C.: National Academies Press, 2008).

^{lxii} See Foa, Hembree and Rothbaum, *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences* on the effectiveness and use of exposure therapy (ET) in clinical settings. Becker et al. address an interesting complication; while the effectiveness of ET is widely documented, only a small minority of clinicians use ET in treatment of PTSD. They suggest that lack of education about and training in ET as well as complicated dosage formulas contribute to the low use of ET. See “A Survey of Psychologists’ Attitudes towards and Utilization of Exposure Therapy for PTSD.”

^{lxiii} Herman, *Trauma and Recovery*; Greben, “The Reestablishment of Trust through Psychotherapy.”

^{lxiv} Herman, *Trauma and Recovery*; Greben, “Reestablishment of Trust”; Brison, *Aftermath: Violence and the remaking of the self*.

^{lxv} Herman, *Trauma and Recovery*, 133-138.

^{lxvi} Potter, “Gender”

^{lxvii} Ehlers, et al “Cognitive Therapy for PTSD: Development and evaluation.”

^{lxviii} Herman, *Trauma and Recovery*, 133; Greben, “Reestablishment of Trust,” 352-53.

^{lxix} Ibid.

^{lxx} Brison, *Aftermath*.

^{lxxi} Ibid, 71.

^{lxxii} Kerner and Fitzpatrick, “Integrating writing into psychotherapy practice: A matrix of change processes and structural dimensions.”

^{lxxiii} Brison, *Aftermath*, 73.

^{lxxiv} See, for instance, Mackenzie and Stoljar (eds.) *Relational Autonomy* and Westlund, “Rethinking Relational Autonomy.”

^{lxxv} Nelson, *Damaged Identities*

^{lxxvi} Nelson, *Damaged Identities*, xiii.

^{lxxviii} Radden and Sadler, *The Virtuous Psychiatrist: Character Ethics in Psychiatric Practice*.

^{lxxix} Potter, “Gender”, Nelson, *Damaged Identities*, Radden, *Moody Minds*, Tekin, “Self-concept Through the Diagnostic Looking Glass: Narratives and Mental Disorder”; Tekin, “How Does the Self Adjudicate Narratives?”; Hacking, “The Looping Effects of Human Kinds”; Baylis “I am Who I am”: On the perceived threats to Personal identity from Deep Brain Stimulation.”